Trinity Health Muskegon & Shelby Infusion Clinics
Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444
Shelby: 72 S. State St. Shelby, MI 49455
Fax (shared): 231-672-3970

Darbepoetin alfa (Aranesp®)

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies

Order Date: ____/____/____ **Site of Service:** ☐ TH Muskegon ☐ TH Shelby

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ **Date of Birth**: ____/____/____ **Weight:** _____kg **Height:** _____cm **Allergies:** _____	**Primary Insurance:** _____ **Member ID:** _____ **Secondary Insurance:** _____ **Member ID:** _____
Diagnosis Diagnosis Code (**ICD-10**): _____ Indication: _____ CKD Stage: _____ Target start date: _____	**Lab Orders** ☐ **Prior to first treatment (within 45 days)** CBC w/diff, Scr, Ferritin, Transferrin, Iron, Folic Acid, Vitamin B12, Erythropoietin level ☐ **Prior to each treatment:** CBC w/diff ☐ **Every 3 months:** ferritin, transferrin and iron ☐ **Annually:** Folate and Vitamin B12

Notify provider and hold dose/ dose adjustment at provider discretion for:

Hemoglobin: ☐ > 11 g/dL ☐ Hg increase > 1 g/dL over 2 weeks ☐ Other: _____

℞ Darbepoetin alfa (Aranesp) subcutaneous injection

☐ _____mcg	☐ Weekly
☐ 0.45 mcg/kg	☐ Every 2 weeks
☐ 0.75 mcg/kg	☐ Every 4 weeks
	☐ Other: _____

Nursing Orders:
Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary: sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN

Provider Name: _____ Provider Signature: _____
Office Phone Number: _____ Office Fax Number: _____
Attending Physician Name: _____
(If ordering provider is an advanced practice practitioner, attending physician required)
Note: This order is valid for 12 months from date of physician signature.